

## Appendix P

### Colorado Medical Assistance Program

### Prior Authorization Procedures and Criteria

### For Physicians and Pharmacists

#### Covered Pharmaceuticals

- Pharmaceuticals that are manufactured by companies that have signed a rebate agreement with CMS
- Pharmaceuticals that are not in a restricted classification

#### Non-Covered Pharmaceuticals

- DESI drugs (Drugs designated by the Food and Drug Administration as Less Than Effective Drug Efficacy Study Implementation medications)

#### Prior Authorizations (PA)

- Prior Authorization criteria is based on FDA approved indications, CMS approved compendia and peer-reviewed medical literature
- Drugs requiring prior authorization are listed on pages 38 through 54

#### Prior Authorization Request (PAR) Process

- PA forms are available by visiting: <http://www.chcpf.state.co.us/HCPF/Pharmacy/nwPAList.asp>
- PA forms can be signed by anyone who has authority under Colorado law to prescribe the medication. Assistants of authorized persons can not sign the PA form
- Only physicians and pharmacists from long-term-care pharmacies and infusion pharmacies who are acting as the agents of the physicians can request a PA
- Pharmacists from long-term-care pharmacies and infusion pharmacy must obtain a signature from someone who is authorized to prescribe drugs before they submit PA forms
- All PA's are coded online into the PA system
- PA requests for Atypical Antipsychotics and Fentanyl must be made by fax.
- Prior Authorizations can be called or faxed to the helpdesk at:

Phone: 1-800-365-4944

Fax: 1-888-772-9696

- As of July 1, 2007, ICD-9 codes can be submitted in the point-of-sale system to override certain prior authorizations. To verify an ICD-9 code contact the PAR Helpdesk at:

Phone: 1-800-365-4944

### Medical Supply Items and Medications

- All supplies, including insulin needles and diabetic supplies are not covered under the pharmacy benefit, but are covered as medical supply items through Durable Medical Equipment (DME)

- Mail PARs for food supplements, medical supplies and diabetic supplies except insulin to:

Claims and PARs

P. O. Box 30

Denver, CO 80201-0030

DME PAR Phone #: 303-534-0279 or toll free 1-800-237-7647

- To find out more about DME policies call:

Renee Robinson: 303-866-5622

- Medications given in a hospital, doctor's office or dialysis unit are to be billed directly by those facilities as a medical item. IV Fluids, meds, etc. may be billed by the pharmacy when given in a long-term care facility or by home infusion.

Drug	Criteria	PAR Length
<b>ACETAMINOPHEN CONTAINING PRODUCTS</b>	A prior authorization is required for dosages of acetaminophen containing products over 4000mg/day of acetaminophen.	Variable
<b>ACNE PRODUCTS</b>  Topical Tretinoin Products and Isotretinoin Products	Prior authorization is required for all topical tretinoin and isotretinoin products. Payment for topical tretinoin therapy and isotretinoin products will be authorized for the following diagnoses: Cystic acne, disorders of Keratinization, psoriasis, neoplasms, comedonal or acne vulgaris. <ul style="list-style-type: none"> <li>➤ <i>Cystic acne, disorders of Keratinization, psoriasis, or neoplasms</i>, do <b>not</b> require previous trials and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for a one-year period.</li> <li>➤ The diagnosis of <i>comedonal</i> does <b>not</b> require previous trial and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for an initial three-month period. <u>IF</u> topical tretinoin therapy is effective after the initial approval period, a prior authorization will be granted for a one-year period.</li> <li>➤ A diagnosis of <i>acne vulgaris</i> <b>requires</b> previous trials and treatment failures on antibiotic and /or topical treatments. If criteria are met, a prior authorization will be granted for a one-year period.</li> </ul>	See criteria
<b>ALBUMIN</b>	Must have an FDA approved indication and given in the client's home or in a long-term care facility for approval. The following are FDA approved indications: <ul style="list-style-type: none"> <li>➤ Hypoproteinemia</li> <li>➤ Burns</li> <li>➤ Shock due to:                             <ul style="list-style-type: none"> <li>▪ Burns</li> <li>▪ Trauma</li> <li>▪ Surgery</li> <li>▪ Infection</li> </ul> </li> <li>➤ Erythrocyte resuspension</li> <li>➤ Acute nephrosis</li> <li>➤ Renal dialysis</li> <li>➤ Hyperbilirubinemia</li> <li>➤ Erythroblastosis fetalis</li> </ul>	One year
<b>ALPHA –1 PROTEINASE INHIBITORS</b>  (Aralast, Prolastin, Zemaira)	FDA approved indication if given in the client's home or in a long-term care facility: <ul style="list-style-type: none"> <li>➤ Prolastin: Emphysema associated with Alpha-1 Antitrypsin Deficiency</li> <li>➤ Aralast: Chronic augmentation therapy in clients having congenital deficiency of Alpha –1 Proteinase Inhibitor with clinically evident emphysema</li> <li>➤ Zemaira: Chronic augmentation and maintenance therapy in clients with Alpha- 1 Proteinase Inhibitor deficiency with clinically evident emphysema</li> </ul> If client is Medical Assistance Program and Medicare eligible, provider must bill Medicare first.	Lifetime

Drug	Criteria	PAR Length
<b>ANABOLIC STEROIDS</b>  Including Androgel	FDA approved indications if given in the client's home or in a long-term care facility: <ul style="list-style-type: none"> <li>➤ Wasting AIDS</li> <li>➤ Hypogonadism in males</li> <li>➤ Corticosteroid-induced Hypogonadism and Osteoporosis</li> <li>➤ Turner's Syndrome in females</li> <li>➤ Delayed puberty in males</li> </ul>	One year
<b>ANOREXIANTS (Diet Pills)</b>	<b>Not Covered</b>	None
<b>ANTI-ANEMIA DRUGS</b> (Oral and injectable drugs)  <i>Drug must have signed rebate</i>	<b>FDA approved indication:</b> Iron Deficiency Anemia  <u>Injectable Drugs</u> [i.e.: Infed (iron dextran), Venofer, Ferrlecit] <ul style="list-style-type: none"> <li>➤ Diagnosis of iron deficiency anemia when oral preparations are ineffective or cannot be used.</li> <li>➤ Must be administered in a client's home or in a long-term care facility</li> </ul>	Lifetime
<b>ANTIEMETICS</b>  (Anzemet, Kytril, Sancuso, Aloxi and Brand Zofran suspension)	As of January 1, 2009, Ondansetron tablets, Ondansetron ODT tablets, Ondansetron suspension, brand Zofran tablets, brand Zofran ODT tablets and Emend are a covered benefit without a prior authorization.  Non-preferred products will be approved for clients who have failed treatment with brand or generic Zofran within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
<b>ANTIHISTAMINES</b>  (ALLEGRA (fexofenadine), fexofenadine (generic Allegra), CLARINEX (desloratadine), CLARITIN (brand), XYZAL (levocetirizine), ZYRTEC (brand))	Effective July 1, 2009, loratadine (generic Claritin) and cetirizine (generic Zyrtec) are a covered benefit without a prior authorization except for dual eligible clients.  Non-preferred antihistamines will be approved for clients who have documented lack of efficacy with two preferred products in the last 6 months. Approval may also be granted for clients who are unable to take preferred products due to allergy, intolerable side effects or significant drug-drug interaction.	One year
<b>ANTIHISTAMINES WITH DECONGESTANTS (Rx)</b>	Effective July 1, 2009, there are no preferred products for this class.  Non-preferred antihistamine/decongestant combinations will be approved for clients who have a diagnosis of seasonal or perennial allergic rhinitis or chronic sinusitis not controlled with nasal steroids alone.	One year
<b>ANTIHYPERTENSIVES</b> Angiotensin Receptor Blockers (ARBs), ARB Combinations, Renin Inhibitors & Renin Inhibitor Combinations  (TEVETEN (eprosartan), TEVETEN-HCT (eprosartan/HCTZ), AZOR (amlodipine/olmesartan), EXFORGE (amlodipine/valsartan), TEKTURN (aliskiren), TEKTURN HCT (aliskiren/HCTZ))	Effective July 1, 2009, ATACAND (candesartan), AVAPRO (irbesartan), BENICAR (olmesartan), COZAAR (losartan), DIOVAN (valsartan), MICARDIS (telmisartan), ATACAND-HCT (candesartan/HCTZ), AVALIDE (irbesartan/HCTZ), BENICAR-HCT (olmesartan/HCTZ), HYZAAR-HCT (losartan/HCTZ), DIOVAN-HCT (valsartan/HCTZ) and MICARDIS-HCT (telmisartan/HCTZ) are a covered benefit without a prior authorization.  Non-preferred ARBs, renin inhibitors, and combination products will be approved for clients who have failed treatment with one preferred product. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)	One year

Drug	Criteria	PAR Length
<b>ANTI-ULCER DRUGS</b>	<b>Effective February 1, 2008, you can find H2 Blockers on page 46 and Proton Pump Inhibitors on page 48.</b>	
<b>ATYPICAL ANTIPSYCHOTICS</b> (oral)  (Risperdal, Abilify and Zyprexa)	<b>For patients 19 years old and above:</b> Abilify: A PA is required for more than one tablet of any particular strength per day. Exception: Abilify 30mg tablet and Abilify 1mg/ml solution. Risperdal: A PA is required for more than one tablet of any particular strength per day. A prior authorization will be approved for twice a day dosing for clients 65 years old or older, long-term care patients, clients with renal and hepatic impairment or for clients with concern of orthostatic hypotension and syncope. Exceptions: 3mg Tablet, 4mg Tablet, 2mg M-Tab, and 1mg/ml Solution Zyprexa: A PA is required for more than one tablet of any particular strength per day. Exception: Zyprexa 20mg tablet and Zyprexa Zydis 20mg tablet. <b>A PA is not required for clients 18 years old and under.</b>	One year
<b>ATYPICAL ANTIPSYCHOTICS</b> (Injectable)  (Abilify, Zyprexa, Geodon and Risperdal)	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility or in a client's home.	One year
<b>BACTROBAN</b>  Nasal Ointment and Cream (Generic Bactroban Ointment does not require a prior authorization)	<b>Bactroban Cream</b> (mupirocin calcium cream) must be prescribed for the treatment of secondarily infected traumatic skin lesions (up to 10 cm in length or 100 cm <sup>2</sup> in total area), impetigo, infected eczema or folliculitis caused by susceptible strains of Staphylococcus aureus and Streptococcus pyogenes. <b>Bactroban Nasal Ointment</b> (mupirocin calcium) must be prescribed for the eradication of nasal colonization with methicillin-resistant Staphylococcus aureus in adult patients and health care workers as part of a comprehensive infection control program to reduce the risk of infection among patients at high risk of methicillin-resistant S. aureus infection during institutional outbreaks of infections with this pathogen.	Cream: One year  Nasal Ointment: Lifetime
<b>BLOOD PRODUCTS</b>  <i>Including MOE and MOF</i>	FDA approved indications if given in the client's home or in a long-term care facility: ➤ Plasma protein fraction; shock due to burns, trauma, surgery; hypoproteinemia; adult respiratory distress syndrome; cardiopulmonary bypass; liver failure; renal dialysis; or hemophilia. ➤	Lifetime
<b>BONE DENSITY INJECTABLES</b> (Didronel, Boniva, Aredia, Miacalcin, Zemplar, Hectorol, Zometa, Pamidronate, and Ganite)	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility or in a client's home.	One year

Drug	Criteria	PAR Length
<b>BOTOX / MYOBLOC INJECTION</b>	<p>FDA approved indication if given in the client's home or in a long-term care facility.</p> <ul style="list-style-type: none"> <li>➤ <i>Cervical or Facial Dystonia</i></li> </ul> <p><i>Not approved for Cosmetic Purposes</i></p>	One year
<b>BRAND NAME MEDICATIONS</b>	<p>As of April 1, 2008, providers should use the Colorado Medicaid Pharmacy PAR Form posted on the web site. Medwatch forms are no longer accepted. The DUR Clinical Manager will continue to accept the Brand Name Request Form until July 1, 2008.</p> <p>Only brand name drugs that have a generically equivalent drug (as determined by the FDA) require a prior authorization. Exceptions to the rule include:</p> <ul style="list-style-type: none"> <li>➤ The brand name drug has been exempted (see the list below)</li> <li>➤ When the reimbursement for a brand-name drug is less expensive than the cost of the generic equivalent</li> <li>➤ The physician is of an opinion that a transition to the generic equivalent of a brand-name drug would be unacceptably disruptive to the patient's stabilized drug regimen</li> <li>➤ The patient is started on a generic drug but is unable to continue treatment on the generic drug as determined by the patient's physician</li> </ul> <p>The following list of drug classes is exempt from the generic mandate rule (no PA is required). Medications used for the treatment of:</p> <ul style="list-style-type: none"> <li>➤ Biologically based mental illness defined in 10-16-104 (5.5) C.R.S.</li> <li>➤ Cancer</li> <li>➤ Epilepsy</li> <li>➤ HIV/AIDS</li> </ul>	One year
<b>COUGH AND COLD (Rx)</b>	<p>Client &lt;21 years: Regular benefit</p> <p>Client ≥ 21 years must have diagnosis of a chronic condition such as COPD or asthma.</p> <p>Guaifenesin 600mg LA is approved for clients having an abnormal amount of sputum.</p>	One year

Drug	Criteria	PAR Length																
<b>COX-2 INHIBITORS</b>  (Celebrex)	<p>Effective September 30, 2004: No PAs will be granted for Vioxx.</p> <p>Effective April 7, 2005: No PAs will be granted for Bextra.</p> <p>PA is required for clients who are 64 years of age and younger. Clients over the age of 65 do not require a PA.</p> <p>A PA will be approved if the COX-2 is prescribed for a FDA approved indication.</p> <table><tr><th>FDA Approved Indication</th><th>Dose and Length of PA</th></tr><tr><td>Acute Pain</td><td>Up to 600mg day 1; 200mg BID for no more than 30 days</td></tr><tr><td>Dysmenorrhea</td><td>Up to 600mg day 1; 200mg BID. One year approval</td></tr><tr><td>Ankylosing spondylitis</td><td>200mg daily; after 6 weeks of 200mg daily dosing if client’s condition has been unresponsive, 400mg daily may be approved. Lifetime approval</td></tr><tr><td>Familial Adenomatous Polyposis</td><td>400mg BID. Lifetime approval</td></tr><tr><td>Osteoarthritis</td><td>200mg daily; 100mg BID. Lifetime approval</td></tr><tr><td>Rheumatoid Arthritis</td><td>100-200mg BID. Lifetime approval</td></tr><tr><td>Juvenile Rheumatoid Arthritis</td><td>Up to 300mg BID. 6 month approval</td></tr></table>	FDA Approved Indication	Dose and Length of PA	Acute Pain	Up to 600mg day 1; 200mg BID for no more than 30 days	Dysmenorrhea	Up to 600mg day 1; 200mg BID. One year approval	Ankylosing spondylitis	200mg daily; after 6 weeks of 200mg daily dosing if client’s condition has been unresponsive, 400mg daily may be approved. Lifetime approval	Familial Adenomatous Polyposis	400mg BID. Lifetime approval	Osteoarthritis	200mg daily; 100mg BID. Lifetime approval	Rheumatoid Arthritis	100-200mg BID. Lifetime approval	Juvenile Rheumatoid Arthritis	Up to 300mg BID. 6 month approval	See chart
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<b>DEPO PROVERA / LUNELLE</b>	<p>FDA Approved Indication if given in the client’s home or in a long-term care facility:</p> <ul style="list-style-type: none"><li>➤ Females: Contraception, uterine bleeding, amenorrhea, endometrial cancer</li><li>➤ Males: Sexual aggression / Pedophilia – Only Depo-Provera will be approved</li></ul> <p>Not approved for administration in the physician’s office – these must be billed through medical.</p>	One year																
<b>EPOETIN</b>  Procrit, Epogen, Aranesp	<p>Approval will be granted only after iron/folate deficiency has been ruled out.</p> <p><b>Clients must meet all criteria in one of the following four areas:</b></p> <ul style="list-style-type: none"><li>➤ A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and Hb of 10g/dL or lower.</li><li>➤ A diagnosis of chronic renal failure, and Hb of 11g/dL or lower</li><li>➤ A diagnosis of hepatitis C, currently taking Ribavirin and failed response to a reduction of Ribavirin dose, and Hb less than 10g/dL (or less than 11g/dL if symptomatic).</li><li>➤ A diagnosis of HIV, currently taking Zidovudine, Hb less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less.</li></ul> <p>Hb results must be from last 30 days.</p> <p>If administrated during dialysis, in a clinic, outpatient setting or a physician’s office, it is not a pharmacy benefit and must be billed on a Colorado 1500-claim form as a medical expense.</p>	<p>One year except for Cancer.</p> <p>Cancer: duration of chemotherapy course.(Approval may be extended by 8 weeks if Hb is still less than 10g/dL after chemotherapy course.)</p>																

Drug	Criteria	PAR Length
<b>ERECTILE DYSFUNCTION DRUGS</b>  Caverject Cialis Edex Levitra Muse Viagra	<p>Effective January 1, 2006, no drugs will be covered for erectile dysfunction.</p> <p>PAs for Viagra for pulmonary hypertension can no longer be approved.</p> <p>Yohimbine: PAs can no longer be approved for erectile dysfunction. Any PAs for use as a mydriatic agent or a vasodilator (not related to erectile dysfunction) may be approved.</p>	<p>Not available</p> <p>Lifetime</p>
<b>FENTANYL PREPARATIONS</b>  Actiq, Fentora and Duragesic Transdermal System	<p>Actiq and Fentora: Approval will be granted if the client is diagnosed with cancer and has already received and is tolerant to opioid drugs for the cancer pain. The PA may be granted for up to 4 lozenges or tablets per day.</p> <p>Duragesic Transdermal System: Effective March 4, 2004, a PA is required for doses of more than 1 Patch/2 Days.</p> <p>For all Fentanyl preparations: If the patient is in hospice, the PA will be automatically granted regardless of the number of doses prescribed.</p>	<p>One year</p>
<b>FLUORIDE PREPARATIONS</b>	<p>Effective February 1, 2008, a prior authorization will not be needed for clients less than 21 years of age.</p> <p>Prior authorization requests for clients 21 years of age and older will be individually reviewed by the state.</p>	<p>N/A</p>

Drug	Criteria	PAR Length
<p><b>FILGRASTIM/ PEGFILGRASTIM / SARGRAMOSTIM</b>  (Neupogen / Neulasta / Leukine)</p>	<p>Prior authorization is required for therapy with filgrastim, pegfilgrastim or sargramostim.</p> <p><b>Prior authorizations for PEGFILGRASTIM will be approved for the following indication if the criterion is met:</b></p> <p><u>Indication:</u> To decrease the incidence of infection due to neutropenia in clients receiving myelosuppressive anti-cancer therapy.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. CBC and platelet count obtained before chemotherapy is administered.</li> </ul> <p><b>Prior authorizations will be approved for FILGRASTIM AND SARGRAMOSTIM for the following indications if the applicable criteria are met:</b></p> <p><u>Indication:</u> To decrease the incidence of infection due to severe neutropenia caused by myelosuppressive anti-cancer therapy.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. Either the post nadir ANC is less than 10,000 cells/mm<sup>3</sup> or the risk of neutropenia for the client is calculated to be greater than 20%</li> <li>➤ Criterion 2. Routine CBC and platelet counts twice weekly</li> </ul> <p><u>Indication:</u> Use in patients undergoing bone marrow transplant and for use after bone marrow transplant.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. Routine CBC and platelet counts at least three times weekly for filgrastim and two times weekly for sargramostim.</li> </ul> <p><u>Indication:</u> For patients undergoing peripheral blood progenitor cell collection and therapy.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. Monitoring of neutrophil counts after four days of treatment.</li> </ul> <p><u>Indication:</u> For filgrastim only, for chronic administration to reduce the incidence and duration of clients with congenital neutropenia, cyclic neutropenia or idiopathic neutropenia.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. CBC and platelet count obtained before treatment with filgrastim begins.</li> <li>➤ Criterion 2. Routine CBC and platelet counts twice weekly during initial four weeks of therapy and during the two weeks following any dose adjustment.</li> </ul> <p><u>Indication:</u> To decrease the incidence of infection due to severe neutropenia in HIV/AIDS clients.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. Evidence of neutropenia Infection exists or ANC is below 750 cells/mm<sup>3</sup></li> <li>➤ Criterion 2. ANC is maintained at Approximately 1,000 cells/mm<sup>3</sup> by filgrastim adjustment</li> <li>➤ Criterion 3. Routine CBC and platelet counts as needed.</li> </ul>	<p>One year</p>

Drug	Criteria	PAR Length
FUZEON	<p>If administered in the physician's office or delivered to physician's office, physician must bill as a medical claim on the 1500 claim form <b>(no PA required)</b>.</p> <p>If administered in the client's home or in a long-term care facility, a prior authorization is required and must meet the criteria below for approval</p> <p>Based on clinical trial data, ENF should be used as part of an <i>optimized</i> background regimen for treatment-experienced clients:</p> <ul style="list-style-type: none"> <li>➤ For treatment-experienced clients with evidence of HIV-1 replication, treatment should include at least one antiretroviral agent with demonstrated HIV-1 susceptibility on the basis of genotypic/phenotypic <i>resistance</i> assays, and <i>two</i> "active" antiretroviral agents. <ul style="list-style-type: none"> <li>○ Clients must have limited treatment options among currently commercially available agents.</li> </ul> </li> <li>➤ Clients must be 18 years of age or older with advanced HIV-1 infection, and not responding to approved antiretroviral therapy.</li> <li>➤ Clients must have a CD4 lymphocyte count less than 100 cells/mm<sup>3</sup> and a viral load greater than 10,000 copies/ml (measurement within the last 90 days).</li> </ul> <p>Past adherence must be demonstrated based on:</p> <ul style="list-style-type: none"> <li>➤ Attendance at scheduled appointments, and/or</li> <li>➤ Prior antiretroviral regimen adherence, and/or</li> <li>➤ Utilization data from pharmacy showing client's use of medications as prescribed</li> <li>➤ Ability to reconstitute and self-administer ENF therapy.</li> </ul> <p>At 24 weeks, clients must experience at least <math>\geq 1 \log_{10}</math> decrease in HIV RNA or have HIV RNA below quantifiable limits to continue treatment with ENF.</p> <p>Clients are not eligible if antiretroviral treatment-naïve and/or infected with HIV-2.</p> <p>Pre-approval is necessary</p> <p>Practitioner must either be Board Certified in Infectious Disease, or be an HIV experienced practitioner. Verification must be produced with the prior approval documents.</p> <p><b>These guidelines may be modified on the basis of other payer formularies and/or the emergence of new data.</b></p>	Six months

Drug	Criteria	PAR Length
<p><b>GROWTH HORMONES</b></p> <p>HUMATROPE NUTROPIN OMNITROPE SAIZEN SEROSTIM ZORBTIVE</p>	<p>Effective 4/1/09, GENOTROPIN, NORDITROPIN and TEV-TROPIN are a covered benefit without a prior authorization.</p> <p>Non-preferred Growth Hormones will be approved if <b>both</b> of the following criteria are met:</p> <ul style="list-style-type: none"> <li>▪ Client failed treatment with two preferred products within the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</li> <li>▪ Client has a qualifying diagnosis: <ul style="list-style-type: none"> <li>➢ Prader-Willi</li> <li>➢ Chronic renal insufficiency/failure</li> <li>➢ Turner’s Syndrome</li> <li>➢ Idiopathic short stature</li> <li>➢ Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma</li> <li>➢ Somatotropin deficiency syndrome</li> <li>➢ Wasting associated with AIDS or cachexia</li> </ul> </li> </ul> <p>★Nutropin will be approved for clients diagnosed with chronic renal insufficiency without having failed on a preferred product.</p> <p><b>Grandfathering</b> Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication.</p>	<p>One year</p>
<p><b>H2 BLOCKERS</b></p> <p><b>Ranitidine capsules and liquid</b></p>	<p><b>Generic H2 Blockers</b> do not require a PA except for ranitidine capsules and liquid.</p> <p><u>Ranitidine capsules</u>: Require the prescribing provider to certify that capsules are “medically necessary” and that the client cannot use the tablets.</p> <p><u>Ranitidine liquid</u>: A prior authorization will be granted for clients with a feeding tube or who have difficulty swallowing. A prior authorization is not required for children under 12 years of age.</p>	<p>One year</p>
<p><b>INTRANASAL CORTICOSTEROIDS</b></p> <p>BECONASE AQ FLONASE NASACORT AQ NASAREL OMNARIS RHINOCORT AQ</p>	<p>Effective 4/1/09, fluticasone (generic FLONASE), NASONEX and VERAMYST are a covered benefit without a prior authorization.</p> <p>Non-preferred Intranasal Corticosteroids will be approved if the client has failed treatment with 2 preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions).</p> <p>★Rhinocort AQ will be approved for pregnant clients without failure of Preferred products.</p>	<p>One year</p>

Drug	Criteria	PAR Length
<b>IVIG</b>	<p>Clients must have one of the following conditions:</p> <ul style="list-style-type: none"> <li>➤ <u>Immunodeficiency disorders:</u> <ol style="list-style-type: none"> <li>1. Common Variable Immunodeficiency (CVID)</li> <li>2. Severe Combined Immunodeficiency (SCID)</li> <li>3. X-Linked Agammaglobulinemia</li> <li>4. X-Linked with Hyperimmunoglobulin M (IgM) Immunodeficiency</li> <li>5. Wiskott-Aldrich Syndrome</li> <li>6. Pediatric Human Immunodeficiency Virus (HIV): <ul style="list-style-type: none"> <li>▪ Clients are less than 13 years of age and CD-4 Count is &gt; 200/mm<sup>3</sup></li> </ul> </li> </ol> </li> <li>➤ <u>Neurological disorders:</u> <ol style="list-style-type: none"> <li>1. Guillain-Barre' Syndrome</li> <li>2. Relapsing-Remitting Multiple Sclerosis</li> <li>3. Chronic Inflammatory Demyelinating Polyneuropathy</li> <li>4. Myasthenia Gravis</li> <li>5. Polymyositis and Dermatomyositis</li> </ol> </li> <li>➤ <u>Chronic Lymphocytic Leukemia (CLL)</u></li> <li>➤ <u>Autoimmune Neutropenia (AN):</u> <ol style="list-style-type: none"> <li>1. Absolute neutrophil count is less than 800 mm</li> </ol> <p>And</p> <ol style="list-style-type: none"> <li>2. Has recurrent bacterial infections</li> </ol> </li> <li>➤ <u>Autoimmune Hemolytic Anemia (AHA)</u></li> <li>➤ <u>Liver or Intestinal Transplant</u></li> <li>➤ <u>Idiopathic Thrombocytopenic Purpura (ITP):</u> <ol style="list-style-type: none"> <li>1. Preoperatively for clients undergoing elective splenectomy with platelet count &lt; 20,000</li> <li>2. Clients with active bleeding &amp; platelet count &lt; 30,000.</li> <li>3. Pregnant women with platelet counts &lt; 10,000 in the third trimester.</li> <li>4. Pregnant women with platelet count 10,000 to 30,000 who are bleeding.</li> </ol> </li> </ul>	<p>One year</p> <p>One year</p> <p>CLL: One year AN: 6 months</p> <p>AHA: 5 weeks ITP: 5 days</p>
<b>LEUKOTRIENES</b>  ACCOLATE ZYFLO	<p>Effective 4/1/09, all SINGULAIR formulations are a covered benefit without a prior authorization</p> <p>Non-preferred Leukotrienes will be approved if <b>both</b> of the following criteria are met:</p> <ul style="list-style-type: none"> <li>▪ Client failed treatment with Singulair in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</li> <li>▪ Client has a diagnoses of Asthma</li> </ul>	One year
<b>LIPIDS/AMINO ACIDS/PLASMA PROTEINS</b>	Approval will be given if administered in the client's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	Lifetime

Drug	Criteria	PAR Length
<b>LHRH/GnRH</b> (Luteinizing Hormone Releasing Hormone/ Gonadotropin Releasing Hormone)	Must be given in the client's home or in a long-term care facility. Prior authorization will be granted for FDA Approved Indications Only: <ul style="list-style-type: none"> <li>➤ <b>Lupron (leuprolide):</b> Prostate Cancer, Endometriosis, Uterine Leiomyomata (fibroids), Precocious Puberty</li> <li>➤ <b>Zoladex:</b> Breast Cancer, Endometriosis, Endometrial Thinning, Prostate Cancer</li> <li>➤ <b>Trelstar:</b> Palliative treatment of Advanced Prostate Cancer</li> <li>➤ <b>Eligard:</b> Palliative-treatment of Advanced Prostate Cancer</li> <li>➤ <b>Viadur:</b> Palliative treatment of Advanced Prostate Cancer</li> <li>➤ <b>Vantas:</b> Palliative treatment of Advanced Prostate Cancer</li> </ul>	One year
<b>OPHTHALMIC ALLERGY</b>  ALAMAST ALAWAY ALOCRIL ALOMIDE ELESTAT EMADINE OPTIVAR	Effective 4/1/09, CROMOLYN, PATANOL, PATADAY and ZADITOR are a covered benefit without a prior authorization.  Non-preferred Ophthalmic Allergy medications will be approved if the client has failed treatment with two preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
<b>OPIOIDS</b> Long Acting – Oral Opioids	Effective July 1, 2009, KADIAN, methadone, and morphine ER are a covered benefit without a prior authorization.  Non-preferred, long-acting oral opioids will be approved for clients who have experienced lack of efficacy with one preferred agent in the last three months. Approval may also be granted for clients who are unable to take preferred products due to intolerable side effects or significant drug-drug interaction.  <u><b>Dosing Frequency</b></u> Quantity allowed will be in accordance with FDA approved dosing frequency. AVINZA will only be approved for once daily dosing. MS CONTIN (brand), ORAMORPH (brand), OXYCONTIN, Oxycodone ER and OPANA ER will only be approved for twice daily dosing.  <u><b>Grandfathering</b></u> Clients who are currently stabilized on a non-preferred, long-acting opioid may be approved to continue therapy with that agent.	One year

Drug	Criteria	PAR Length
<b>OTC PRODUCTS</b>	<p>Medical Necessity</p> <ul style="list-style-type: none"> <li>➤ Aspirin, Insulin and Plan B are covered without a PA</li> <li>➤ Prilosec OTC: <i>See Proton Pump Inhibitor's section</i></li> <li>➤ Guaifenesin 600mg LA is covered for clients having an abnormal amount of sputum</li> <li>➤ Quinine Sulfate <i>is no longer covered</i> for leg cramps</li> <li>➤ Herbal products are not a benefit except for cranberry tablets, which are covered for urinary tract infections</li> <li>➤ Diabetic needles and supplies are not a prescription benefit and should be billed as supply</li> <li>➤ Broncho saline is not covered- refer to Sodium Chloride section</li> <li>➤ Cough and Cold Products must have a diagnosis of a chronic respiratory condition for which these medications may be prescribed or otherwise be medically necessary</li> <li>➤ Antihistamine (w/ decongestant) must have a diagnosis of seasonal or perennial allergic rhinitis or chronic sinusitis or otherwise be medically necessary</li> <li>➤ Nicomide is approved for acne</li> </ul> <p><i>Nursing Facilities: Please provide OTC floor stock list.</i></p>	One year
<b>OXSORALEN</b>	Approval will be granted with diagnosis of: Myosis; Fungoides; Psoriasis or Vitiligo	One year
<b>PROMETHAZINE</b>	A Prior authorization is required for all routes of administration for clients under the age of two. Children under the age of two should not use Promethazine. Promethazine is contraindicated in such patients because of the potential for fatal respiratory depression.	One year
<b>PROPECIA</b>	<b><i>Not covered for hair loss</i></b>	One year
<b>PROTON PUMP INHIBITORS</b> (Prilosec, Nexium, Kapidex, Helidac, Protonix, PrevPac, Aciphex, and Zegerid)	<p>Effective January 1, 2009, Prilosec OTC and Prevacid capsules and solutabs are a covered benefit without a prior authorization.</p> <p>Approval for a Non-preferred agent must meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>➤ Clients must have tried and failed treatment with Prilosec OTC <b>and</b> Prevacid in the last 24 months. Failure is defined as; lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction. Children under 12 only need to fail on one of the preferred agents before receiving a non-preferred agent.</li> <li>➤ Client must have one of the following diagnoses: Barrett's esophagus, duodenal ulcer, erosive esophagitis, gastric ulcer, GERD, GI bleed, H. pylori, heart burn (for Prilosec OTC only), hypersecretory conditions (Zollinger-Ellison), NSAID-induced ulcer, pediatric esophagitis, recurrent aspiration syndrome or ulcerative GERD.</li> <li>➤ The diagnosis must be confirmed by: GI Specialist, endoscopy, X-Ray, biopsy, blood test or breath test.</li> </ul> <p>Twice daily dosing will only be approved for: Barrett's esophagus, GI bleeds, H.pylori, hypersecretory conditions (Zollinger-Ellison), and spinal cord injury patients with any acid reflux diagnosis.</p> <p>Aciphex, Protonix and Zegerid will <b>not</b> be approved for clients less than 18 years of age.</p> <p>Duel eligible clients can only qualify for Prilosec OTC. These clients must have a diagnosis of heartburn and failed treatment on the preferred PPI product available on their Part D plan.</p>	One year

Drug	Criteria	PAR Length
PROVIGIL	See STIMULANTS	
REBATE DISPUTE PRODUCTS	Medical necessity of specific product – – there are many of them.	One year
<b>RESPIGAM/SYNAGIS</b> Respiratory Syncytial Virus (RSV) Prevention and Treatment	<p><b>A Prior Authorization can be approved if:</b>  The medication will be administered in the client’s home; the client is under age 2 at the start of the current RSV season (as determined by the CDC); and who meets one of the following:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of Chronic Lung Disease (CLD) AND having one for more of the following clinical needs during the previous 6 months: <ul style="list-style-type: none"> <li>○ Supplemental Oxygen</li> <li>○ Regular use of inhaled or oral bronchodilators</li> <li>○ Recent use of corticosteroid therapy</li> <li>○ Regular or intermittent use of diuretics to treat pulmonary disease</li> </ul> <b>*A maximum of FIVE (5) monthly doses will be approved.</b> </li> <li>2. Diagnosis of Congenital Heart Disease AND having one or more of the following criteria: <ul style="list-style-type: none"> <li>○ Receiving medication to control congestive heart failure (Diuretics or Antihypertensives)</li> <li>○ Suffer moderate to severe pulmonary hypertension</li> <li>○ Suffer Cyanotic Heart Disease</li> </ul> <b>*A maximum of FIVE (5) monthly doses will be approved.</b> </li> <li>3. Any infant up to 6 months of age, born 29 to less than 32 weeks gestation  <b>*A maximum of FIVE (5) monthly doses will be approved.</b> </li> <li>4. Any infant up to 12 months of age, born at 28 weeks or less gestation  <b>*A maximum of FIVE (5) monthly doses will be approved.</b> </li> <li>5. Any infant younger than 3 months of age at the start of the RSV season, born at 32 to less than 35 weeks gestation and meets one of the following risk factors: <ul style="list-style-type: none"> <li>○ Currently attends day care</li> <li>○ Has a sibling younger than 5 years of age</li> <li>○ Congenital abnormalities of the airway</li> <li>○ A neuromuscular condition that compromises handling of respiratory secretions</li> </ul> <b>*A maximum of THREE (3) monthly doses will be approved or until the child reaches 3 months of age.</b> </li> <li>6. Infants up to 2 years of age with hemodynamically significant heart disease defined as having one or more of the following: <ul style="list-style-type: none"> <li>○ Infants receiving medication to control congestive heart failure</li> <li>○ Infants with moderate to severe pulmonary hypertension</li> <li>○ Infants with cyanotic heart disease</li> </ul> <b>*A maximum of FIVE (5) monthly doses will be approved.</b> </li> </ol>	See individual approval criteria

Drug	Criteria	PAR Length
<b>RESPIRATORY INHALANTS</b>		
<b>INHALED ANTICHOLINERGICS &amp; ANTICHOLINERGICS COMBINATIONS</b>  (ATROVENT (brand) and DUONEB (brand))	Effective July 1, 2009, albuterol/ipratropium (generic Duoneb) and ipratropium (generic Atrovent) are a covered benefit without a prior authorization. Also, ATROVENT HFA, COMBIVENT and SPIRIVA inhalers are a covered benefit without a prior authorization.  Non-preferred anticholinergic inhalants and anticholinergic combination inhalants will require a brand-name prior authorization.	One year
<b>INHALED BETA2 AGONISTS (Short Acting)</b>  <u>Inhalers</u> ALUPENT, XOPENEX and MAXAIR  <u>Solutions</u> ACCUNEb, AIRET, ALUPENT, PROVENTIL, VENTOLIN and XOPENEX	Effective July 1, 2009, generic albuterol solution and PROAIR HFA, PROVENTIL HFA and VENTOLIN HFA inhalers are a covered benefit without a prior authorization.  Non-preferred, short acting beta2 agonists will be approved for clients who have failed treatment with one preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).  <b>Grandfathering:</b> Clients currently stabilized on a non-preferred beta2 agonist can receive approval to continue that agent for one year if medically necessary.	One year
<b>INHALED BETA2 AGONISTS (Long Acting)</b>  <u>Solutions</u> BROVANA and PERFORMIST  <u>Inhalers</u> FORADIL and SEREVENT <b>Inhaled Corticosteroids</b>	There are no preferred products for this category.  Non-preferred, long acting beta2 agonists will be approved for clients with moderate to severe asthma who are currently using an inhaled corticosteroid and require add-on therapy, or for clients with moderate to very severe COPD.  <b>Grandfathering:</b> Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.	One year
<b>INHALED CORTICOSTEROIDS</b>  AEROBID, ASMANEX and AZMACORT	Effective July 1, 2009, PULMICORT respules, PULMICORT flexhaler, FLOVENT HFA, FLOVENT (50, 100, and 250)mcg diskus and QVAR inhalers are a covered benefit without a prior authorization.  Non-preferred inhaled corticosteroids will be approved for clients who have failed treatment with one preferred agents. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.)  <b>Grandfathering:</b> Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.	One year

Drug	Criteria	PAR Length
<b>INHALED CORTICOSTEROIDS COMBINATIONS</b>  (ADVAIR HFA and SYMBICORT)	Effective July 1, 2009, ADVAIR diskus is a covered benefit without a prior authorization.  Non-preferred corticosteroid combinations will be approved for clients meeting both of the following criteria: <ul style="list-style-type: none"> <li>➤ Client has a qualifying diagnosis of asthma or COPD</li> <li>➤ Client cannot take preferred drug due to lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</li> </ul> <b>Grandfathering:</b> Clients currently stabilized on a non-preferred agent can receive approval to continue that agent for one year if medically necessary.	One year
<b>REVATIO</b>	Approval will be granted for a diagnosis of pulmonary hypertension.	Lifetime
<b>REVIA/NALTREXONE</b>	As of March 1, 2007, a PA is no longer required.	N/A
<b>SANDOSTATIN</b>	Approved for: acromegaly; carcinoid tumors; and vasoactive intestinal peptide tumors.	Lifetime
<b>SEDATIVE/HYPNOTICS</b>  LUNESTA (eszopiclone) AMBIEN (zolpidem) - Brand SONATA (zaleplon)	Effective 4/1/09, AMBIEN CR, ROZEREM and zolpidem are a covered benefit without a prior authorization.  <b>★Drug limits have been removed from this category.</b>  Non-preferred sedative hypnotics will be approved for clients who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)  <b>Children:</b> Prior authorizations will be approved for clients 18 years of age and older.  <b>Duplications:</b> Only one agent in this drug class will be approved at a time. Approval will not be granted for clients currently taking a long-acting benzodiazepine such as Halcion (Triazolam) or Restoril (temazepam).	One year
<b>SKELETAL MUSCLE RELAXANTS</b>  AMRIX ER, carisoprodol, chlorzoxazone, DANTRium (brand), FEXMID, FLEXERIL (brand), LIORESAL (brand), NORFLEX, orphenadrine, PARAFLEX, PARAFON FORTE, RELA, REMULAR, ROBAXIN (brand), SKELAXIN, SOMA, VANADOM and ZANAFLEX (brand)	Effective July 1, 2009, baclofen, cyclobenzaprine, dantrolene, tizanidine and methocarbamol are a covered benefit without a prior authorization.  Non-preferred skeletal muscle relaxants except for carisoprodol will be approved for clients who have documented lack of efficacy with two preferred agents in the last 6 months. Approval may also be granted for clients who are unable to take preferred products due to allergy, intolerable side effects or significant drug-drug interaction.  <b>Authorization for carisoprodol will be given for a maximum of 3 weeks for clients with acute, painful musculoskeletal conditions who have failed treatment with two preferred products.</b>  <b>Tapering of carisoprodol:</b> Due to potential withdrawal symptoms, tapering is recommended when discontinuing high doses of carisoprodol. A one month approval will be granted for clients tapering off of carisoprodol.	One year except for carisoprodol which will only be approved for 3 weeks

Drug	Criteria	PAR Length
<b>SMOKING CESSATION (Rx &amp; OTC)</b>	<p>Must have documentation of enrollment in behavior modification program. This can be given in the physician's office or over the phone.</p> <p>Medical Assistance Program will pay for only <b>one product</b> at a time but a client may receive multiple strengths of a product or multiple products during the two 90-day paid benefit periods.</p>	Two 90-day paid benefits per year
<b>SODIUM CHLORIDE</b> For inhalation use	<p>Broncho Saline is <b>not</b> covered as a drug benefit.</p> <p><b>Sodium Chloride 0.9%:</b> Only the 3cc unit dose is covered, if the client is sight-impaired and used in the client's home.</p> <p><b>Sodium Chloride 3% and 7% vial:</b> Nebulizer treatment for clients with cystic fibrosis and other pulmonary diseases for mucolytic therapy done in the home.</p> <p>All other requests for sodium chloride (inhalation use) must be billed through medical.</p>	Lifetime

Drug	Criteria	PAR Length
<b>STATINS</b> ALTOPREV (lovastatin ER) ALTOCOR (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin) ADVICOR CADUET SIMCOR VYTORIN	<p>Effective 4/1/2009, LIPITOR, CRESTOR, pravastatin and simvastatin are a covered benefit without a prior authorization.</p> <p>Non-preferred Statin/Statin combinations will be approved if the client has failed treatment with 1 preferred products in the last 24 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</p> <p><b>Children:</b> Altoprev, Advicor and Vytorin will be approved for clients 18 years of age and older. Caduet, fluvastatin and lovastatin will be approved for clients 10 years of age and older.</p>	<p>One year</p>
<b>STIMULANTS</b> Provigil/Strattera/Dexedrine/ Focalin/ Metadate CD/ Daytrana/ Metadate ER/Ritalin (brand) and Adderall (brand)	<p>Effective October 1, 2008, Adderall XR, Focalin XR, Vyvanse, Concerta and generic Adderall (amphetamine salts) and generic Ritalin (methylphenidate) are a covered benefit without a prior authorization as long as the age limitations are met.</p> <p>Non-preferred agents will be approved for clients who have documented lack of efficacy with two Preferred products in the last 6 months; however, certain exceptions exist for Provigil and Strattera. Please see the criteria below for Provigil and Strattera. Approval may also be granted for clients who are unable to take Preferred products due to allergy, intolerable side effects, contraindications or significant drug-drug interaction.</p> <p>In addition:  Non-Preferred agents will only be approved for FDA and official compendium indications.</p> <ul style="list-style-type: none"> <li>▪ Strattera will be approved for clients with a diagnosis of ADHD and ADD.</li> <li>▪ Provigil will be approved for Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, Shift Work Sleep Disorder, Multiple Sclerosis related fatigue or ADHD.</li> <li>▪ Daytrana will be approved for clients who have difficulty swallowing and a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, or traumatic brain injury.</li> <li>▪ All other Non-preferred products will be approved for clients with a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, or traumatic brain injury.</li> </ul> <p>And</p> <p>Non-Preferred agents will only be approved for FDA approved age limitations.</p> <ul style="list-style-type: none"> <li>▪ Provigil will be approved for clients 16 years of age and older.</li> <li>▪ Adderall, Adderall XR, Dexedrine and Dextrostat will be approved for clients 3 years of age and older.</li> <li>▪ All other medications in this class will be approved for clients 6 years of age and older.</li> </ul> <p><b>Strattera:</b> Clients with ADD or ADHD will not need to fail on two Preferred products if the client also has one of the following conditions: history of substance abuse, low weight, tics, Tourette's syndrome, anxiety or OCD. If a client does not have one of these additional conditions, the client will need to fail on two Preferred products.</p>	<p>One year</p>

Drug	Criteria	PAR Length
<b>STIMULANTS</b> (cont.)	<p><b>Provigil:</b> Clients will not need to fail on two Preferred products if they meet the FDA approved indications and age limitation.</p> <p><b>Grandfathering</b> Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication.</p>	
<b>THROMBOLYTIC ENZYMES</b>	Approved for <b>IV Catheter Clearance or Occluded AV Cannula</b> if given in client's home or long term care facility.	One year
<b>TPN PRODUCTS</b>	Approval will be given if administered in the client's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	Lifetime
<b>TRAMADOL</b>	Tramadol is not approved for more than 400mg/day.	N/A
<b>TRIPTANS</b>  (Axert, Amerge, Frova, Relpax, Zomig and Treximet)	<p>As of January 1, 2009, brand and generic Imitrex tablets, nasal spray and injection and Maxalt tablets and Maxalt MLT tablets are a covered benefit without a prior authorization.</p> <p>Non-preferred products will be approved for clients who have failed treatment with one preferred product within the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</p> <p>Quantity limits will apply to Preferred and Non-preferred products. Please refer to the Drug Quantity Limits document at <a href="http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132">http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132</a> for more information.</p>	
<b>VACCINES</b>  Flu  Hepatitis B  Pneumonia	If administered in physician's office, must bill on Colorado 1500 form. If administered in Residential Treatment Center or equivalent must be prior authorized. (Not covered for regular clients – only long-term care facilities).	One year
<b>VERSED</b>  Midazolam	<p>Approved if given in the client's home or in a long-term care facility and given for:</p> <ul style="list-style-type: none"> <li>➤ Preoperative sedation or anesthesia</li> <li>➤ Terminally ill clients with Cancer</li> </ul>	One month

Drug	Criteria	PAR Length
VITAMINS (Rx)	<p><b>Effective July 1, 2009, vitamins considered a medical food by the FDA are not a covered benefit. Please see the Department website for a full list of medical foods.</b></p> <p><b>Prescription vitamins except for prenatals will be authorized for:</b></p> <ul style="list-style-type: none"> <li>➤ ESRD, CRF, renal insufficiency, diabetic neuropathy or renal transplant</li> <li>➤ Clients under the age of 21 with a diagnosis disease that prohibits the nutrition absorption process as a secondary effect of the disease.</li> </ul> <p><b>Folic Acid Vitamins</b></p> <p>In addition to the above general vitamin criteria, approval for folic acid vitamins will be granted if one of the following criteria is met:</p> <ul style="list-style-type: none"> <li>➤ Currently taking Methotrexate or Alimta</li> <li>➤ A diagnosis of folic acid deficiency (megaloblastic and macrocytic anemia are the most common). Some drugs or other conditions may cause deficiency -- Approval will be granted for these indications IF the client has current folic acid deficiency and documented by the provider.</li> <li>➤ <b>For Female Clients:</b> Approval will be granted for the prevention of a neural tube defect pregnancy and for the prevention of miscarriages.</li> <li>➤ Homocysteinemia</li> </ul> <p><b>Cyanocobalamin/Folic Acid/Pyridoxine</b></p> <p>In addition to the above general vitamin criteria, approval will be granted for clients:</p> <ul style="list-style-type: none"> <li>➤ with Homocysteinemia or Homocystinuria</li> <li>➤ on dialysis</li> <li>➤ with or at risk for cardiovascular disease</li> </ul> <p><b>Prenatal Vitamins are a regular benefit for pregnant clients (indicated on Rx) and for 60 days postpartum. Prenatal vitamins are not covered for any other condition.</b></p> <p><b>Prescription Vitamin D and K products no longer require a prior authorization.</b></p>	One year
VIVITROL	Approval will be given if administered in the client's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	One year
XENICAL  For D5A Fat Absorption Decreasing Agents	Effective 5/1/2008, Xenical is not covered.	N/A
XOLAIR	Approval will be given if administered in the client's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	One year